IN THE MATTER OF THE ARBITRATION BETWEEN

HIGHLAND CHATEAU HEALTH CARE CENTER	)	**FMCS NO. 07-0125**
"EMPLOYER"	)	
	)	**DECISION AND AWARD**
And	)	
UNITED FOOD AND COMMERCIAL WORKERS UNION LOCAL 789	)	**RICHARD R. ANDERSON ARBITRATOR**
"UNION"	)	**JULY 7, 2007**

APPEARANCES

For the Employer:

George J. Stunyo, President Autumn Creek Consulting
Mary Beth Lacina, Administrator
Robin Przepiora, Director of Nursing
Danielle Fontaine, Nurse Manager
Kathleen Miller, Licensed Practical Nurse

For the Union:

Roger J. Jensen, Attorney
Mary Fukar, Grievant/Nursing Assistant Registered
Jeanine Owusu, Business Agent

JURISDICTION

The hearing in above matter was conducted before Arbitrator Richard R. Anderson on May 22, 2007 in South St. Paul, Minnesota. Both parties were afforded a full and fair opportunity to present its case. Witness testimony was sworn and subject to cross-examination. Exhibits were introduced and received into the record. The hearing closed on May 22, 2007. Post-Hearing Briefs were mailed by the Employer on June 21, 2007 and received on June 22, 2007, and mailed by the Union on July 2, 2007 and received on July 3, 2007.[1] The record was then closed and the matter was taken under advisement.

This matter is submitted to the undersigned pursuant to the terms of the parties' collective bargaining agreement that was effective from July 1, 2005 through June 30, 2007.[2] The language in Article XVI [ARBITRATION] provides for the filing, processing and arbitration of a grievance. Section 9.2 of this Article defines the jurisdiction of the Arbitrator, and Section 9.3 establishes the Arbitrator's sole decision-making authority.

THE ISSUE

The parties stipulated that the issue was, "Whether the Employer discharged the Grievant, Mary Fukar, in violation of Article 8, Section 8.1 of the collective bargaining agreement, and if so, what is an appropriate remedy?

[1] The simultaneous mailing date was July 2, 2007.
[2] Joint Exhibit No. 1

BACKGROUND

The Employer is a long term, rehabilitation and transitional health care center located in the city of St. Paul, Minnesota. The Union represents all non-professional employees including Nursing Assistant Registered (NAR). The bargaining unit, which consists of approximately 100 employees, is set forth in Article II [RECOGNITION OF UNION]. The parties have a history of collective bargaining dating back to the late 1960's or early 1970's.

The Union, through Business Agent Jeanine Owusu, filed a grievance on May 5, 2006 protesting, "*…the termination of Mary Fukar from Highland Chateau on November 21, 2006 as per the Collective Bargaining Agreement Article 8 Section 8.1 employees may only be discharged for "just cause".*"

The parties were unable to resolve the grievance during the grievance processing steps and the Union filed for arbitration with the State of Minnesota Bureau of Mediation Services (BMS).[3] The undersigned was notified of being selected as the neutral Arbitrator by e-mail from Employer's counsel dated February 16, 2007.

RELEVANT CONTRACT PROVISIONS

ARTICLE 1. RECOGNITION OF UNION

Section 1.1 *The Employer recognizes said Union as the sole representative of all of its non-professional regularly scheduled employees within the bargaining unit certified by the National Labor Relations Board, excluding registered nurses, licensed practical nurses, office clerical employees, temporary employees, administrators, guards and supervisors as defined in the National Labor Relations Act and on call employees, for the purpose of collective bargaining with respect to the hours of labor, rates of pay and working conditions herein specified.*

[3] The exact dates of the aforementioned activites are unknown.

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ARTICLE 8. TERMINATION OF EMPLOYMENT AND DISCIPLINE

Section 8.1: *Employees may not be suspended, demoted or discharged except for just cause. No grievance relating to any disciplinary action shall be valid unless submitted to the Employer in writing within ten (10) days after the suspension, demotion or discharge in question. In case of discharge, the employee affected may request and shall receive from the Employer in writing the reason for said dismissal.*

ARTICLE 9: ARBITRATION

SECTION 9.1: *Any dispute relating to the interpretation of or adherence to the terms and provisions of this Agreement shall be handled in accordance with the following procedures:*

Step 1. *The aggrieved employee and/or Union shall attempt to adjust the grievance with the Employer.*

Step 2. *If the grievance is not resolved in Step 1, it shall be reduced to writing, shall specify in detail the alleged violation of the Agreement, and shall be received by the Employer no later than fifteen (15) calendar days following the Step 1 meeting. Grievances relating to wages shall be timely if received by the Employer no later than sixty (60) calendar days following the date of receipt of the check by the employee.*

Within seven (7) calendar days following receipt of the grievance by the Employer, representatives of the Employer and the Union shall meet and attempt to resolve the grievance. The time for said meeting may be extended by mutual agreement.

Step 3*. If the parties are unable to resolve the grievance in Step 2 they may by mutual agreement, take this matter to Federal Mediation and Conciliation Services.*

Step 4. *If the grievance is not resolved in Steps 2 or 3, either party may refer the matter to arbitration. Any demand for arbitration shall be in writing and must be received by the other party within ten (10) calendar days following the Step 2 or Step 3 meeting. The Employer and the Union shall attempt to agree on a neutral arbitrator who shall hear and determine the dispute. If no agreement is reached, the arbitrator shall be selected from a list of seven (7) neutral arbitrators to be submitted to the parties by the Federal Mediation and Conciliation Service. The Employer and Union shall each alternately strike one (1) name, and the order of striking shall be determined by chance. The remaining arbitrator, after each party has made three (3) strikes, shall hear and determine the dispute.*

Section 9.2:*The authority of the arbitrator shall be limited to making an award relating to the interpretation of or adherence to the written provisions of this Agreement, and the arbitrator shall have no authority to add to, subtract from or modify in any manner the terms and provisions of this Agreement. The award of the arbitrator shall be confined to the issues raised in the written grievance and the arbitrator shall have no power to decide any other issue.*

Section 9.3:*The award of the arbitrator shall be made within thirty (30) calendar days following the close of the hearing. The award of the arbitrator shall be final and binding upon the Employer, Union and employees involved. The fees and expenses of the neutral arbitrator shall be divided equally between the Employer and the Union.*

FACTS

The Grievant, Mary Fukar, is a 50+ year old native of Liberia who immigrated to the United States in 1980 and became a U. S. citizen in 1996. She was initially employed at the Employer's facility on June 19, 2000 and worked as a NAR on 2 East during the day shift from 6:30 a. m. to 3:00 p. m. under the direct supervision of Charge Nurse Kathy Miller until she was terminated on November 21, 2006.[4] The Grievant testified that she voluntarily moved next door to the Employer's facility so that she would be readily available for work. As a result she was frequently called on short notice to substitute for absent staff.

The Employer maintains a progressive disciplinary policy that is not set forth in the Agreement. There is no evidence that the Union played a role in developing this policy or that it was ever disseminated to employees. This policy has a five-step disciplinary procedure. 1. Verbal Warning, 2. Verbal Warning, 3. Written Warning, 4. Suspension and 5. Discharge. Section 8.1 of the Agreement has a "just cause" standard involving suspensions, demotions and discharges.

[4] Unless otherwise indicated hereafter, all dates are in the year 2006.

The evidence established that the Grievant in the last few months of her employment incurred a number of disciplinary actions that began on February 26th and culminated with her discharge on November 21st.[5] Nursing Home Administrator Mary Lacina, who had been the Administrator for approximately two years at the time of the hearing, testified that she has the ultimate responsibility for personnel administration including issuing disciplinary action. On February 28th, she issued the Grievant a verbal warning for conduct that occurred on the 26th. According to Lacina, a resident was upset and crying because the Grievant did not follow the Employer's infection control policies. The verbal warning states that a "*Res reported that Mary was 'mean' & 'dirty'. Infection control issues – 'washed my bottom & threw rag on my pillow'. Description of treatment 'rough & mean'*."

Nurse Manager Danielle Fontaine is the manager of all nursing staff on the second floor and had been employed at the facility for approximately one and one half years at the time of the hearing. She testified that she issued a verbal warning to the Grievant dated May 9th, which the Grievant signed, for conduct occurring on May 5th. This warning was two fold.[6] First, the Grievant failed to have another person assist her in transferring a resident from her bed via a Hoyer, a lift used to transfer residents from their beds to wheelchairs. The Grievant also allowed two residents to be toileted at the same time where they could possibly observe each other

Fontaine also testified that she had performance related issues with the Grievant on October 10th. According to Fontaine, the Grievant informed her that she (Fontaine) was

[5] There is no record that she had been previously disciplined.
[6] Employer Exhibit No. 1A

not aware of the difficulties of her job and requested that Fontaine follow her around and observe her. Thereafter, Fontaine initiated a "shadow" of the Grievant while she engaged in nursing care from 6:30-9:15 a.m. on October 17th. As a result of the "shadow", the Grievant received a verbal warning.[7] The verbal warning, which the Grievant refused to sign, cited the Grievant's failure to follow the plan of care for residents including her failure to follow infection control procedures, having missing documentation and failing to report "refusals" or other important information to nurses.[8]

Fontaine further testified that she issued a written warning to the Grievant on November 3rd for conduct on that day, which the Grievant also refused to sign.[9] This warning cited the Grievant's continued refusal to perform certain job functions properly. It included a slow work pace and improper time management, not getting out to the dinning room to help with the feeding of residents until the end of breakfast time and not following proper procedures for transferring patients.

Fontaine also testified that she issued another warning to the Grievant on November 16th, which she also refused to sign.[10] The warning stated, "*As a result of an ongoing abuse investigation another complaint was received regarding the cares Mary gave this resident. The resident complained that 'her black morning aid* (sic) *was rough with her'.*" Fontaine testified that although the warning did not specifically cite it, the warning involved other misconduct on the part of the Grievant. During the investigation of the bruises of resident "J", a number of residents and staff were interviewed. As a result Fontaine determined that the Grievant was still having resident care issues including not

[7] Employer Exhibit No. 2
[8] Refusing directives of the staff person.
[9] Employer Exhibit No. 3
[10] Employer Exhibit No. 4

using proper infection control, not picking up residents' clothes, not giving proper peri-care and not listening to residents' needs. It was also determined that the Grievant never reported the bruising of resident "J", which she should have been aware of. This warning resulted in a two-day suspension with the caveat that any more complaints on her handling of residents would result in her discharge.

Under cross-examination Fontaine testified that she first became aware of the bruises on resident "J" on Wednesday November 15th after the NAR, who was working the evening before, brought it to the attention of the facility's Social Worker. Fontaine personally saw the bruises on the 15th. She stated there were approximately 7-10 quarter sized bruises on each of the inner thighs, which appeared to be caused by fingers. The color of the bruises were blue and purple with some beginning to fade indicating that the bruising had occurred over a period of time. She believed that the earlier bruises could have occurred as far back as Sunday the12th. Fontaine did not know whether the Grievant worked on Sunday the 12th. Fontaine also acknowledged under cross-examination that one of the reasons for the suspension was that it was common to suspend employees for two days during abuse investigations.

The Grievant's employment time records[11] show that the Grievant was off work on Saturday and Sunday November 11th and 12th. She worked on Monday and Tuesday, the 13th and 14th, and was off on the 15th. On Monday the 13th, the Grievant testified that she had gotten resident "J" ready for a shower, which is given twice a week to residents, and called her nurse (an RN named Maudeline) to do a skin assessment as

11 Employer Exhibit No. 6

there were bruises on the inner thighs of resident "J". She testified that she pointed out to Nurse Maudeline that some of the marks were turning yellow indicating that they were not made that day. She told Nurse Maudeline to note on the resident assessment report form (Resident Body Audit) that some of the marks were old.[12]

The Resident Body Audit form for Monday November 13th shows no bruising being marked and the words "skin intact" after the "comments heading".[13] It appears that Nurse Maudeline signed the report form.[14] It also has the written name "Mary" after the place for the NAR's signature, which is noticeably different than the Grievant's signature on the Friday November 10th report form.[15]

The Grievant further testified that, upon returning to work on Thursday the 16th, Nurse Manager Danielle Fontaine, who reports directly to Director of Nursing (DON) Robin Przepiora, instructed her to accompany Fontaine to her office. The Grievant stated that once in the office, where they were alone, Fontaine told her that from now on she was not to care for resident "J". When the Grievant asked "why", Fontaine told her that she could not say anything now, but resident "J" has bruises on her. According to the Grievant, when it appeared that she was being accused of bruising resident "J", she questioned how she could have possibly done it, adding that she never has a need to touch her in the groin area (diaper her) because she goes to the bathroom by herself.

[12] When a NAR is preparing a resident for a bath or shower, a Nurse is summoned to do a skin assessment of the resident. The Grievant as well as Nurse Manager Fontaine testified that it was the nurse's responsibility to do the "body audit" and also fill out the skin assessment report and sign it. The NAR is also suppose to sign the report.

[13] Employer Exhibit No. 7

[14] Maudeline did not testify.

[15] This report was received after the close of the hearing pursuant to this Arbitrator's request; therefore it was not subject to examination. This report, however, does not appear to be signed by the Grievant since the writing is totally different from the way it is signed in the November 10th report. There is only a single written name "Mary" on the report. The tail of the "y" in "Mary" is a loop that is similar to the loop in tail end of the "g" of the Nurse's signature. The Grievant's signature on the 10th is signed with her full name and has a straight line for a "y" rather than a loop in the tail of the letter. The signature of the Grievant on the 10th is identical to her signatures on the warning notices that she signed.

Fontaine then said she was not accusing her, only that resident "J" reported that her morning black aide was rough with her. The Grievant responded by saying that the morning aide that substitutes for her when she is absent is also black and over-weight. She also told Fontaine that she had been caring for resident "J" for the past two years and had never had a problem with her. Finally, the Grievant said that resident "J' does not always want to get up for breakfast and exhibits anger directed at her.

The Grievant then testified that she was also directed to go with Fontaine to DON Przepiora's office where she had a discussion with Przepiora who informed her that she was being suspended for two days. According to the Grievant, she asked "why", Przepiora told her they were conducting an investigation because of the bruises on resident "J". The Grievant then questioned Przepiora on her right to suspend her during an investigation, adding that she was not the only person who was taking care of resident "J". The Grievant said that Przepiora then told her she was not being suspended for the bruises; but rather because she failed to follow orders and she (Przepiora) was not satisfied with the information the Grievant was giving her.

Przepiora testified further that she became aware of the bruises of resident "J" on Wednesday November 15th, and pictures were then taken.[16] Thereafter, on the 16th she asked the Grievant about the bruises, who then gave conflicting answers. First, she did not see the bruises, then she saw them and then she did not see them since she was never in the position during her care of the resident because of the way she

[16] The pictures, which were not entered as an Exhibit, but circulated to the hearing participants, clearly show multiple bruises in various stages of discoloration.

administered care. The notes that Przepiora testified she made after her conversation with the Grievant are as follows:[17]

Investigation of Bruises on J.J

> Mary Fukar- 11/16/2006 approx. l: 30 pm. Mary worked Monday and Tuesday 7-3. Mary states the "marks" started a while ago. When asked if the bruises looked like the pictures on Monday and Tuesday Mary said, "Yes".
>
> Mary then stated she is not sure what she saw on Monday and Tuesday. Mary stated she never really looked at the resident's inner thighs. Stated she didn't know it was a bruise. Just saw a mark. This was on the resident's shower day Monday. Mary was extremely hard to follow. Her statements changed frequently throughout this conversation.
>
> When asked about the statement that Judith made "morning black aid is rough" Mary stated" When you get people up against their will they get mad at you".

Przepiora added that all staff is trained to report bruises as it is mandated by the State, and she was concerned that the Grievant never saw and/or reported them. Further, she believed, based upon the investigation, that the Grievant caused the bruises; however, this was never substantiated during the course of the investigation.

Finally, Przepiora, during direct examination, testified that she did not issue the November 16th suspension of the Grievant for bruising resident "J"; rather, it was for the suspicion of bruising resident "J", and also because of the complaints from residents and their families concerning the Grievant's patient care that were uncovered during the course of the bruising investigation.

Under cross-examination, Przepiora testified that it was possible for the bruises to date back to the 12th or 13th of November. She also testified that resident "J" could not tell them when or who caused the bruises since her cognitive status varies. She is in

[17] Employer Exhibit No. 4A

her 80's or 90's and suffers from schizophrenia and dementia. Przepiora also indicated during her cross-examination that the November 16th suspension was partially attributed to resident "J" complaining about the rough treatment of the "morning black aid". She believed this person was the Grievant since other aides performing care on the resident did not fit this description, adding that the State mandates giving credibility to residents irrespective of the resident's condition. It is also the Employer's policy and State requirement that a staff member being investigated for resident abuse is not allowed to care for that resident during the course of the investigation.

Przepiora also testified that she was positive that she only told the Grievant not to take care of resident "J" "for the rest of the day" and not "in the future" as the Grievant alleged. Later during cross-examination, she qualified her answer by saying she was positive; but not positive enough to "swear on the Bible".

The Grievant was on suspension Friday the 17th and Monday the 20th. When she returned to work on November 21st, she was issued a final warning and discharged.[18]. The warning signed by Administrator Lacina stated that the Grievant, "*Refused to get up resident when nurse Kathy Miller instructed. Said wouldn't do it unless the DON or Administrator assessed the Resident*. *Failure to follow directive of a Supervisor.*"

Charge Nurse Kathryn Miller, who is a Licensed Practical Nurse (LPN) and has been employed at the facility for one and one-half years, testified that she has been a supervisor on 2 East for approximately a year and one-half; and supervised the Grievant during this time period until her discharge. Miller testified that, based on her opinion and experience, the Grievant was difficult to supervise. According to Miller, the

[18] Employer Exhibit No. 5

Grievant was very resistant to supervision, was non-directable and typically was on the verge of being insubordinate.

Miller testified further that on the morning of November 21st, she was the Charge Nurse on 2 East where the Grievant was assigned as the fourth floor NAR. Miller stated that she went over the morning[19] report of resident "J"[20] with the Grievant at approximately 7:00 a.m. She informed the Grievant that resident "J" had bruises on her person, that they had already been reported and that the bruising was under investigation. She then directed the Grievant to get the resident "J" up for the day. [21] Miller testified that the "get up" period for residents on 2 East is, usually from 7:15-9:00 a.m.[22] According to Miller, the Grievant acknowledged this directive by nodding her head "yes".

During cross-examination, Miller acknowledged that the Grievant was also responsible to get up, one at a time, eight to ten other residents; and bring them to the dinning room for breakfast, which normally is served for 2 East residents until 9:00 a.m. Miller also acknowledged in her testimony that the Grievant, as well as other NAR's, could prioritize the order in which residents were "gotten up"

At approximately 8:00 a.m., Miller testified that she did not observe resident "J" in the dinning room. She ran into the Grievant in the hallway of 2 East and again directed her to get resident "J" up. Again, the Grievant acknowledged this directive by nodding her head "yes". Miller further testified that at approximately 8:40 a.m. she noticed that

[19] The morning report has is an overview of patient's status from the preceding shift.
[20] For confidentiality reasons the patient is only been identified by this letter.
[21] Getting up is waking, dressing, oral care, hygiene, grooming, peri-care (private areas) and bringing them to the dinning room for breakfast.
[22] Other higher-level management staff testified that he breakfast period ended at 8:30 a. m.; however, it appears that this period frequently ran until 9:00 a.m.

resident "J" was still not up. She again instructed the Grievant to get resident "J" up. The Grievant then stated that she was not going to get the resident up because of her bruises, and wanted her to get the DON or the Administrator before she did.[23]

DON Robin Przepiora testified that when she arrived at the facility at approximately 9:00 a.m., there was a voice mail message from Charge Nurse Miller asking her to come up stairs as soon as she arrived as the Grievant was refusing to get a resident up. When she arrived upstairs she saw the Grievant who followed her into the room of resident "J" and explained that she did not want to get the resident up until she (Przepiora) saw the new bruises. According to Przepiora, she looked at the bruises and told the Grievant that she was aware of them. She then told the Grievant she should have gotten the resident up, adding what would have happened if she had not come in at all that day. Thereafter, the Grievant got the resident up, which had to be after 9:00 a.m. Przepiora also testified that it was policy for 2 East residents normally to be in the dinning room for breakfast by 8:30 a.m.

Przepiora further testified that it was the Employer's policy, which had been reiterated to staff members many times in monthly meetings, that the staff had to follow the orders of Charge Nurses even if they did not agree to the instructions. At approximately 9:30 a.m. Przepiora went to the office of Administrator Lacina and reported the Grievant's conduct regarding resident "J". It was then determined by Lacina, with her input, that the Grievant should be discharged for insubordination and not following the instructions of a supervisor based upon the Employer's progressive

[23] Miller testified that she became aware of the multiple bruises on the inner and outer thighs of resident "J" the day before and was not aware at this time that the Grievant was being accused of causing the bruises

disciplinary policy. Lacina testified that she considers insubordination and the failure to follow a supervisor's directives to be serious acts of misconduct. Discharge was appropriate because of the seriousness of the misconduct. Lacina testified further that they had counseled the Grievant on many occasions and did not think that the Employer could do anything to change the Grievant's behavior and resident care, thus discharge was appropriate.

The Grievant testified that she was reluctant to get resident "J" up because of her instructions not to care for her. She testified that she was told by Przepiora on November 16th, that she was not suppose to care for resident "J" anymore.

She further testified that she was never specifically instructed at any time by Charge Nurse Miller to get resident "J" up. The Grievant stated that it was getting close to 9:00 a.m. and she saw that resident "J" was still not up.[24] She assumed that another NAR would be caring for her because of Przepiora's directive on November 16th. According to the Grievant, she then went searching for the aide that she thought was supposed care for resident "J" because she was instructed not to. When she could not find the aide, she then went into the room of resident "J", pulled back her covers and noticed additional bruising on the resident's hands that she was not aware of before.

The Grievant testified that she went searching for Miller and told her about the new bruises. Miller on the other hand testified that the Grievant never told her that resident "J" had new bruises, only that she had bruises and wanted the DON or Administrator to come to the resident's room. They then walked toward the room of resident "J". The

[24] The Grievant testified that all residents are suppose to be in the dining room by 8:30 a.m.; however, in reality the actual time they are all finally there is closer to 9:00 a.m.

Grievant stated that at this point she and Miller parted company, and she did not know whether Miller went into the resident's room.

The Grievant further testified that thereafter DON Przepiora arrived on the floor. When the two of them were in the room of resident "J", she pointed out the resident's new bruises to Przepiora. According to the Grievant, Przepiora stated that she was aware of them and instructed her to get the resident up, which she did. She testified that she then brought resident "J" to the dining room, which was shortly after 9:00 a. m.

The Grievant testified under cross-examination that Charge Nurse Miller never specifically instructed her at any time on the 21st to get resident "J" up. Adding, that Miller was lying in her testimony.[25] Rather, the Grievant said that she fully intended to get the resident up, but only after the DON or the Administer cleared her to do so in light of the new bruises. She was, as she testified, afraid to be accused of further abuse of resident "J". This is why she left a message with the receptionist to have them come up to the floor when they arrived.

The Grievant further testified that at approximately 1:00 p.m. she was instructed by Nurse Manager Fontaine to go with her to Administrator Lacina's office. When they arrived at the office, Lacina and Union Business Agent Jeanine Owusu were already there. Lacina informed the Grievant that she was being terminated because of past complaints and because she refused to get resident "J" up as instructed by Charge Nurse Miller. The Grievant testified that she attempted to explain her side of the story but was cut-off by Lacina.

[25] She also contended in her testimony that supervision was out to get her and staff members had lied about her.

POSITION OF THE EMPLOYER

The Employer's position is that it did not discharge the Grievant in violation of the just cause standard of Article 8, Section 8.1 of the Agreement. The Employer argues that it has a moral obligation to the residents and their families and a legal obligation to the State of Minnesota to care for residents. Most residents are in their 70's and 80's, and are unable to bathe, eat, dress, take "meds" or handle their personal toiletry needs by themselves. The Grievant had substantial difficulty over the years to comply with the Employer's rules, regulations and procedures. She was repeatedly counseled in order to bring her patient care up to the Employer's moral and legal obligations. The Grievant failed to embrace what needed to be done to bring her into conformity with the rules, regulations and procedures required for patient care.

The Employer argues further that it has a five step progressive disciplinary procedure—verbal warning, verbal warning, written warning, suspension and discharge. It followed that progression in disciplining the Grievant; and in fact, gave the Grievant extremely favorable treatment by issuing her three verbal warnings instead of two before moving progressively to a written warning. Further, the Employer afforded the Grievant the right to Union representation during each step of the disciplinary process; but she chose not to utilize it until the discharge step of the disciplinary procedure. Additionally, there were no grievances filed over any discipline until she was issued the suspension, which was later dropped when the grievance was filed over her discharge.

The Employer further argues that the Grievant gave conflicting testimony regarding getting resident "J" up. First, she said that she was not going to get her up because she was instructed not to care for her anymore. Later, under cross-examination she testified

that she was never instructed to get the resident up, rather, she always fully intended to do so.

POSITION OF THE UNION

It is the Union's position that the Employer did not have just cause pursuant to Section 8.1 of the Agreement to discharge the Grievant. The Union argues that the Grievant did not honor Charge Nurse Miller's instructions to get resident "J" up on November 21st because she was aware that there were new bruises on the resident, and she was "petrified" that she would again be accused of bruising the resident. In addition, DON Przepiora told her on November 16th, when she was suspended, that she was not allowed to care for resident "J" in the future. The Grievant's fears were understandable given the facts of her two-day suspension for allegedly bruising resident "J".

The Grievant first saw the resident's bruises on Monday November 13th, during the course of the resident's shower and body audit. Some of the marks were already turning yellow, which indicated age. Since the Grievant was off for the weekend of the 11th and 12th, it is unlikely that she could have caused the bruises.

The primary evidence to support the allegation that the Grievant bruised resident "J" was the statement from the resident that, "the black morning nurse was rough" on her. The testimony at the hearing disclosed that there are other black NAR's who care for resident "J" and it was possible that one of them was working the weekend of the 11th and 12th. The testimony also disclosed that resident "J" is suffering from dementia. It is possible the statement made by the resident about her black morning aide being rough on her was not regarding care that would cause bruises. Rather, it could be that the

resident was referring to being forced to get up when she did not want to. Having dementia, the resident could be referring to any conduct she did not like as being "rough".

The Grievant was given a two-day suspension even though management representatives who investigated the incident had doubts about the Grievant's guilt. Both Nurse Manager Fontaine and DON Przepiora testified that they were unable to substantiate the exact cause of the bruising of resident "J".

It is understandable why the Grievant was reluctant to get resident "J" up. If she was accused again of causing bruising on resident "J", she faced possible termination. After she discovered new bruises on resident "J", the only way she would not again be falsely accused would be to have the Don or Administrator see the bruises first before she got the resident up. Thus, the Grievant's caution was reasonably justified and is a defense to the claim of insubordination. At the very least it is an extenuating circumstance that requires a reduction in the penalty to something less than discharge.

The Grievant also reasonably believed that she had been instructed not to take care of resident "J" in the future. She believed that on November 21st, another NAR would be providing care to the resident after she had been given specific instructions by the DON the week before not to care for her. It is also quite possible that both the Grievant's and Przepiora's recollection of what they told the Grievant on November 16th is accurate. The Grievant could have interpreted Przepiora's remarks to mean in the future and not just for the rest of the day since she is an immigrant from East Africa with English as a second language. If no time limit was specified it is quite possible Przepiora meant the rest of the day while the Grievant understood it to cover the future.

Finally, the Union argues that the combination of the fear that the Grievant would be again falsely accused of bruising resident "J" along with the fact that she believed she had been instructed not to care for the resident by the DON explains and justifies her refusal to honor the instructions of Charge Nurse Miller. Further, as DON Przepiora testified, Charge Nurse Miller did not have authority to countermand an order given by the DON to an aide.

OPINION

The issue before the undersigned is whether the Employer had just cause pursuant to Section 8.1 to discharge the Grievant. This issue presents a well-settled two-step analysis: first, whether the Grievant engaged in activity which gave the Employer just and proper cause to discipline her; and second, whether the discipline imposed was appropriate under all the relevant circumstances. It is the Employer's burden to show that the Grievant engaged in conduct warranting discipline and that the appropriate discipline was a termination.

The Employer has a five-step progressive disciplinary policy. It imposed the penalty of discharge pursuant to this policy based on the Grievant's disciplinary history. This policy appears to be unilaterally imposed since there is no evidence that it was the subject of negotiations or was ever adopted by the Union. Rather, the parties have negotiated strict "just cause" language in Section 8.1 of the Agreement. Absent just cause language, the burden on the Employer would be to establish that the conduct engaged in by the Grievant justified discipline and that the discipline warranted a Step 5 discharge because the Grievant had previously occupied Step 4 (Suspension) of its progressive disciplinary policy.

A progressive disciplinary policy does not, per se, justify discharge. Such a perfunctory assessment of discipline is inconsistent with a just cause standard. When the Employer entered into the just cause standard in Section 8.1, it created more than a carte blanche right to discharge the Grievant solely because its progressive disciplinary policy.

In discharge cases where just cause is the standard, a significant quantum of proof is required to show not only that a grievant engaged in the misconduct alleged, but also that the misconduct justifies discharge. In this matter, it is whether the Grievant violated the Employer's policy regarding Charge Nurse Miller's supervisory directives; and whether this conduct, per se, satisfies the just cause standard warranting discharge because of its seriousness.

Although just cause has no universally accepted definition, arbitrators often determine the existence of just cause by applying the well-known “Seven Tests Standard". Arbitrator Daugherty in Grief Brothers Cooperage, 42 LA 555, first articulated these tests. 558 (1964).[26] In these cases Professor Daugherty notes that a negative answer to any of these questions may well mean that there is insufficient cause for the discipline imposed. These tests are as follows:

1. Did the Company give to the employee forewarning or foreknowledge of the possible consequences of the employee’s conduct?
2. Was the Company’s rule or managerial order reasonably related to the orderly efficient and safe operation of the Company's business?
3. Did the Company before administering the discipline to the employee make an effort to discover whether the employee did in fact violate or disobey a rule or order of management?
4. Was the Company’s investigation fair and objective?
5. At the investigation, did the "judge" obtain substantial evidence of proof that the employee was guilty as charged?

[26] See also. Enterprise Wire Co., 46 LA 359 (Daugherty 1966).

6. Has the Company applied its rules, orders and penalties evenhandedly and without discrimination to all employees?

7. Was the degree of discipline administered by the Company in a particular case reasonably related to (a) the seriousness of the employee's proven offense and (b) the record of the employee in his service with the Company?

When the particularized facts surrounding the Grievant's discharge are fully examined, it is apparent that no discipline is appropriate, much less discharge. The evidence clearly shows that the Grievant had resident care issues that resulted in various disciplinary actions. Although there is conflicting evidence adduced from the Grievant, it is clear that Charge Nurse Miller instructed the Grievant to get resident "J" up for breakfast on the morning of November 21st. The evidence is also clear that the Grievant at one point informed Miller that she wanted the DON or Administrator present before she administered care to resident "J".

It is equally clear that DON Przepiora informed the Grievant on November 16th that she was not allowed to care for resident "J". Although Przepiora meant this directive to apply only to the remainder of the day, she could not with absolute certainty be sure this specific time frame was mentioned. The Grievant interpreted this directive to mean from that day forth. It is understandable that the Grievant would interpret the directive this way. She had been accused of abusing resident "J" during her last workday resulting in her suspension. It is reasonable to conclude that she was afraid of administering care to this resident. This is especially understandable after she observed new bruises on the hands of the patient on November 21st, her first workday back following her suspension.[27] While Charge Nurse Miller may have informed the Grievant that they aware of the resident's

[27] The new bruises were first reported in the Resident Body Audit report form on November 17th while the Grievant was on suspension. Employer Exhibit No. 7.

bruises, the Grievant, who had seen the previous bruises, had no way of knowing that management was aware of the additional bruises she observed on the hands of resident "J". It is also understandable that even if DON Przepiora had never issued a previous directive to not care for resident "J", she would want the DON or Administrator present before she engaged in any care of resident "J" for fear once again of being accused of bruising that resident. Finally, there is no evidence to suggest that the Grievant had engaged in any insubordinate behavior in the past. This appeared to be an isolated incident based upon peculiar circumstances.

All of these factors mitigate against any strong discipline, much less discharge. There was also no evidence that the Grievant's decision to wait for the DON or Administrator compromised the care of resident "J", other than she was served breakfast a little late.

The Employer also falls short in the application of the "Seven Test Standard" for just cause. First, the Grievant was never warned of any consequences if she failed to follow Charge Nurse Miller's directives. If she had been forewarned that the failure to immediately get resident "J" up would result in discipline, much less discharge, the Grievant may have complied with the directive. It also appears that the decision to discharge the Grievant was made and carried out before a fair and objective investigation was conducted. It appears that the only investigation over the alleged insubordination was to rely solely on the word of Charge Nurse Miller, with no further investigation or inquiry. The Grievant was never asked for her side of the story before any disciplinary action was implemented. Rather, it appears that Lacina, who has the final word on personnel matters, took the word of Przepiora who took the word of

Charge Nurse Miller and made the decision to terminate the Grievant without ever talking to Miller or the Grievant. Lacina had no idea if there were any extenuating circumstances surrounding the Grievant's refusal to get resident "J" up. The termination notice was already prepared and the Union's Business Agent was notified before the Grievant was summarily discharged on the afternoon of November 21st. Clearly, the punishment just does not fit the "crime". The Grievant's actions, even crediting the Employer, just do not rise to the level of work place capital punishment given all the mitigating circumstances present herein.

Finally, the Employer went to great lengths to justify termination by litigating the Grievant's suspension as proof that she is a recidivist violator of acceptable resident care and Employer policies. While the suspension is not before me in this arbitration, it appears that this disciplinary action is also flawed.[28] The evidence strongly indicates that the Grievant was suspended solely for the alleged abuse of resident "J". While State regulations may mandate a suspension of a nursing home employee during the course of an investigation involving abuse, that suspension, by no means, should have been disciplinary. Further, it appears that the inadequate resident care issues, which were not specifically addressed in the suspension action, were an afterthought; and in all likely-hood, encompassed incidents that the Grievant had already been disciplined for. Thus, it is conceivable that if her suspension had been wrongfully imposed she would not have been facing the discharge phase of the Employer's progressive disciplinary policy.

[28] The suspension grievance is not included in this arbitration and I have no authority to rule on it.

In conclusion, the evidence clearly establishes that the Employer failed in its burden to establish that it had just cause in terminating the Grievant. Even assuming arguendo that some discipline was justified, the evidence clearly established that discharge was not the appropriate discipline for all of the reasons set forth herein.

AWARD

IT IS HEREBY ORDERED that the grievance in the above entitled matter be and is hereby sustained for the reasons set forth in this Decision.

IT IS FURTHER ORDERED the discharge of Mary Fukar is rescinded and any reference to the discharge be expunged from in her personnel file, consistent with my Decision herein.

IT IS FURTHER ORDERED that Mary Fukar be reinstated to her former position; and be made whole for any loss of wages, economic benefits, seniority, or any other benefits or rights or privileges suffered as a result of the Employer's action, less any interim earnings.

The undersigned Arbitrator will retain jurisdiction in this matter for a period of forty-five (45) days from the receipt of this Award to resolve any matters relative to implementation.

Dated: July 7, 2007

Richard R. Anderson, Arbitrator